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DAVID E. JANSSEN
Chief Administrative Officer

June 7, 2004

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

SACRAMENTO UPDATE

Conference Committee Actions on Saturday, June 5, 2004

The Budget Conference Committee met Saturday for approximately four hours beginning its deliberations at 10:00 am. The Committee worked through a number of conference items including Corrections and then received an overview of Education issues from the Legislative Analyst's Office (LAO) and the Department of Finance (DOF). The next meeting is scheduled for today, and will begin with K-12 education.

The Conference opened with an overview from the DOF on the General Fund condition including Conference Committee actions through noon, Friday, June 4, 2004. By DOF's accounting, the Assembly version of the budget has a deficit of almost $600 million. DOF indicated that this figure was misleading because, at a minimum, the Assembly version does not include a General Fund reserve. In addition, DOF noted that there were several items that were not taken into account in the Assembly Version. DOF estimated the total of these "threats" to the General Fund at $3.4 billion, including the absence of a reserve.

DOF computes this shortfall by adding the Governor's May Revision reserve of approximately $1 billion to the $600 million shortfall for a total deficit of $1.6 billion. According to DOF, while the Assembly included the $1.3 billion in savings attributable to the May Revision local government package, it did not include the constitutional amendment and statutory changes that are part of that package in the Budget.

Therefore, according to DOF, the savings are not supportable. In response to DOF's comments, the Chair, Senator Chesbro (D., Humboldt Co.) agreed to place the local government issues on the agenda for this week. The addition of the local government package amount of $1.3 billion to the previous $1.6 billion increases DOF's estimate of the shortfall to approximately $2.9 billion.

The Department of Finance also objected to a $477 million unallocated reduction that the Assembly made to the Department of Corrections budget. They indicated that the reduction was not supportable because negotiations with the California Correctional Peace Officers Association have not been concluded, and that unallocated reductions applied to the Department of Corrections in the past either had to be reduced or resulted in substantial deficiencies. Lastly, DOF stated that the Assembly failed to include $99 million for the Trial Courts that was part of the Governor's agreement with the Courts. Addition of these two items increases DOF's estimate of the deficit to an estimated $3.4 billion.

DOF also pointed out that the Assembly increased the draw-down from the Proposition 57 bonds by $1 billion instead of using a similar amount of pension obligation bonds (POB's) as proposed by the Governor. The Assembly budget version essentially swaps the timing of the two debt issuances. The Governor proposed the POB's for FY 2004-05 and the Proposition 57 draw-down for FY 2005-06, while the Assembly did the reverse. Conference Committee Vice-Chair Steinberg (D., Sacramento Co.) defended the action indicating that he does not think that all of the POB legal issues have been resolved, notwithstanding the apparent settlement on the current POB suit brought by the Howard Jarvis Taxpayer's Association.

Highlights of Actions of Interest to the County

Statewide Fingerprint Imaging System. The County opposes elimination of this program. The Conferees left this item open for further discussion.

State Funding of County Medi-Cal Eligibility Processing. The Conference Committee acted to approve the Assembly Version which limits State payments for county eligibility worker wage increases to the greater of the average COLA for State workers, or the California Necessities Index, which could result in a loss of up to $5.4 million in funding for DPSS.

TANF Probation—The Conferees approved County-supported funding for county probation, including $134.3 million from the State General Fund in addition to $67.1 million in TANF funding, and Directed the Board of Corrections to seek other sources of funding, including Federal funds, for county probation services.

Medi-Cal Redesign

As previously indicated in our report on the May Revision, the Administration has removed the Medi-Cal Redesign effort from the FY 2004-05 budget process and declared its intent to submit a Federal Medicaid waiver proposal, and requisite statutory changes to the Legislature on August 2, 2004. The Administration has added stabilization of safety net hospital financing to its list of objectives for Medi-Cal Redesign which also includes program simplification, tiered benefit structures, co-payments, and expansion of managed care.

While the initial phase of the Medi-Cal Redesign stakeholder process has concluded, the Administration has recently convened meetings with safety net hospitals to outline its concepts to modify Medi-Cal supplemental payments. Specifically, the Administration is proposing to change the Medi-Cal Disproportionate Share Hospital (DSH) and SB 1255 programs to allow increased use of organized systems of care (i.e., managed care), and, in their view, address Federal concerns about Intergovernmental Transfers (IGTs). The main aspect of the Administration's approach would substantially replace IGTs with an alternative financing model known as Certified Public Expenditures (CPEs) which would be made by county and University of California hospitals.

On June 3, 2004, the Administration met with representatives of safety net hospitals, including the County, to discuss the providers' observations and technical issues related to the Administration's concepts. Details about the providers' concerns are contained in the attached letter. Among the concerns expressed were California's inadequate Medicaid share, the pitfalls of trading IGTs for CPEs, and whether the Administration's concept promotes safety net hospital stability. In response, the Administration agreed to provide a multi-year analysis for further discussion.

Assembly Labor Committee Hearing on Worker Safety in the Adult Film Industry

On Friday, June 4, 2004, the Assembly Labor Committee held a hearing in Van Nuys on the subject of worker safety in the adult film industry. The only legislator in attendance was committee chair Paul Koretz.

The format for the four-hour hearing involved four panels: The State and Local Government Role in Protecting Workers' Safety; Industry Perspective and Response; Health Perspective: Transmission Risk Assessment and Solutions; and Additional Policy and Constitutional Concerns. The panel discussions were followed by lengthy public comment. Jonathan Fielding, Director of Public Health, represented the County on the initial panel. He made several recommendations requiring legislation including: 1) required use of condoms; 2) mandatory testing and vaccination; 3) education and

training; and 4) required monitoring. Generally, members of the panel agreed with his views, however, none of the other panels felt legislation would be beneficial. Industry representatives testified that mandatory legislation would drive business out of state, because technology has made both production and distribution fairly easy. Panelists felt the County, the State and the industry, itself, have made great strides in voluntary testing and oversight, and that process should continue.

Koretz ended the hearing with the thought that there may be more hearings, and that mandatory testing legislation will not move this year.

We will continue to keep you advised as the Conference Committee progresses through its agenda.

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MAL:JF:ib

Attachment

c: Executive Officer, Board of Supervisors
County Counsel
Local 660
All Department Heads
Legislative Strategist
Coalition of County Unions
California Contract Cities Association
Independent Cities Association
League of California Cities
City Managers Associations
Buddy Program Participants

Attachment

P.E.A.C.H., INC.
Private Essential Access Community Hospitals

CALIFORNIA HEALTHCARE ASSOCIATION

CAPH
CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

CALIFORNIA children's HOSPITAL ASSOCIATION

May 27, 2004

S. Kimberly Belshé
Secretary
Health and Human Services Agency
1600 9th Street, Suite 460
Sacramento, CA 95814

Dear Secretary Belshé:

Thank you for convening the May 11, 2004 meeting with hospital industry and Agency officials to discuss the State's concepts for reconfiguring Medi-Cal payments to safety net hospitals. We are very pleased that the State has added stabilization of safety net hospitals to the goals of Medi-Cal Redesign.

However, we have concerns as to whether the concept presented at the meeting will achieve this mutual goal. Given that California's safety net already is in crisis, it is imperative that proposals to alter the financing structure include a comprehensive analysis and an assurance of future security for these vital institutions. In this vein, we offer the following observations:

California's Medicaid Share. Among all states, California is last in per beneficiary Medicaid spending, and far below others in Disproportionate Share Hospital (DSH) payments per Medicaid and uninsured. While there are many reasons for the disparities, the effects are clear – California is not getting a fair share of Federal Medicaid funds relative to other states despite high numbers of low-income underinsured and uninsured persons. We strongly urge that the State's effort to pursue a Medicaid waiver and/or the renewal of the Selective Provider Contracting Program (SPCP) waiver be aimed at securing more Federal Medicaid funds. We estimate that, based on information available on the Kaiser Family Foundation's website, a move from 51st to just 50th place would add $1.3 billion in additional Federal Medicaid funding to California.

Intergovernmental Transfers (IGTs). IGTs have saved the State General Fund billions of dollars that otherwise would have been required to finance the State's share of SB 855, SB 1255 and GME hospital payments. While we acknowledge the pressure from the Centers for Medicare and Medicaid Services (CMS) about the use of IGTs, it is equally important to recognize that they are lawful, and have been instrumental in stabilizing safety net hospitals.

It also appears that Congress sent a somewhat different signal just last week. By removing Medicaid cuts from the budget conference reconciliation language, the members did not reinforce CMS' stance on IGTs. It is in the State's interest to advocate for preserving the use of IGTs in negotiations with the Federal Government. The suggested alternative, increasing reliance

on Certified Public Expenditures (CPEs) while preserving IGTs for private DSH hospitals, may prove a too limited and inflexible approach to meet the needs of safety net facilities over time.

Safety Net Hospital Stability. Public and private safety net hospitals are the major source of health care for the uninsured as well as many Medi-Cal and Healthy Families beneficiaries. In addition, safety net hospitals are critical elements of local emergency and trauma care systems. Many of these hospitals are in crisis or near-crisis, and nearly all public hospitals are experiencing significant budget reductions this year.

While aspects of the State's hospital financing concept may be worthwhile, it is difficult to evaluate it in terms of stability without a multi-year analysis. Among the factors that need to be considered in this analysis are the effects of Medi-Cal fee-for-service volume declines and the impact on the SPCP waiver that would result from the transition of the aged, blind and disabled into managed care. The proposal lacks structural elements allowing the state to provide additional funding in the future, thereby appearing to assure stability for the state, but leaving ambiguous whether that outcome would be achieved for the safety net.

We are unable to properly analyze the proposal without the information mentioned above, and therefore request that you provide a five-year extension of the model to help us gauge the extent to which it will provide the stability for the safety net that we all seek. We offer the following set of initial questions to draw attention to areas of the concept that remain unclear. We hope that these observations will enhance the process toward our shared goal of stabilizing California's safety net.

Sincerely,

California Healthcare Association

California Children's Hospital Association

California Association of Public Hospitals and Health Systems

Private Essential Access Community Hospitals

University of California

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cc: David Topp, Assistant Secretary, HHS
Sandra Shewry, Director, Department of Health Services
Tom McCaffrey, Chief Deputy Director, Department of Health Services
Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services

Threshold Questions

1. Use of Certified Public Expenditures (CPE)

Shifting the non-federal share of Medicaid hospital safety net payments to CPEs raises significant questions relating to the scope of allowable costs, cost finding methodologies, and a reconciliation process. How does the Department envision defining these items? How does the state reconcile its cost finding approach with recent CMS activity to narrow the scope of allowable hospital costs, such as the DSH related provisions in HR 1, and policies requiring the exclusion of costs relating to furnishing hospital services to undocumented patients in other CPE funded payment programs?

2. Multi-year Analysis

A thorough evaluation of the state's proposal requires a multi-year financial analysis. Given the proposal's heavy reliance on CPEs, the analysis should include adjustments for possible changes relating to hospital costs, including significant declines related to the movement of Aged, Blind and Disabled (ABD) into Medi-Cal managed care. A five-year financial analysis demonstrating the effect of changes in hospital costs on hospital payments and the underlying assumptions for each year would facilitate a proper evaluation.

3. Role of Supplemental Payments

A fundamental element of the state's proposal is the maintenance of non-DSH supplemental payments above the CPE amounts. How would the Medi-Cal inpatient upper payment limit (UPL) be computed for these payments? In other California CPE programs the aggregate payments allowed under the CPE effectively function as the UPL. Under the state's proposal, how would the UPL be designed to allow payment above the CPE amount? This analysis is an integral component of the five-year financial analysis demonstrating the effect of changes in hospital costs on hospital payments, as are the underlying assumptions related to the UPL for each year.

Further, a critical piece of the supplemental payments remain funded by IGTs. Does the state foresee that the new program would be based on mandatory IGTs and be formula based rather than voluntarily provided IGTs and discretionary payments awards? Does the state anticipate the IGT-funded payment growing if public hospital costs decline? If so, on what basis? Will a decline or increase in the public hospital payments result in a reduction/increase in IGTs that support private hospitals? How are public hospital payments and IGTs to support private hospitals linked? Will Medi-Cal managed care days/revenues be allowed for purposes of the new supplemental payment program?

4. Facility Specific Payments

The model presented shows a statewide aggregate picture, which does not reflect the impact on a facility-specific basis. Under the current payment structure, there is significant variation in Selective Provider Contracting Program supplementals (SB 1255, GME, SB 1732), SB 855 DSH payments, and the underlying hospital costs. A thorough evaluation of the proposal requires an examination of any potential changes in the flow of payments and the impact on a facility-

specific basis over multiple years. Facility-specific detail underlying the model is instrumental in a multi-year analysis.

5. DSH Payment

The state's proposal appears to use a different CPE cost finding method for inpatient fee-for-service payments and SB 855 DSH payments. Why wouldn't CMS require a consistent CPE approach to all payments? What impact would a consistent cost finding method have on all the payment components of the analysis? Further, the state's proposal assumes that payments can vary to "make hospitals whole." The current SB 855 DSH statute is predicated on uniformity in DSH payments among hospital types. What will be the basis and rationale for new variability in SB 855 distributions?

6. Waiver Approach

What waiver approach does the state envision pursuing and how will budget neutrality be computed? How will the budget neutrality assessment impact hospital safety net payments over the next five years?